

FILED OCT 28 1948

Registration District No. **278**

Primary Registration District No. **2A54**

Registrar's No. **110**

1. PLACE OF DEATH:

(a) County **PIKE**
(b) City or town **LOUISIANA**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **PIKE CO. HOSPITAL**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **7 WKS. 1 DAY**
(Specify whether years, months or days)
In this community **7 WKS. 1 DAY**

3. (a) PRINT FULL NAME **JAMES DONALD KELLY**

3. (b) If veteran, name war **—** 3. (c) Social Security No. **—**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Infant**
6. (b) Name of husband or wife **—** 6. (c) Age of husband or wife if alive **—** years
7. Birth date of deceased **September 2, 1948**
(Month) (Day) (Year)

8. AGE **1** Years **22** Months **—** Days **—**
If less than one day hr. min.

9. Birthplace **LOUISIANA** **MO. O.**
(City, town, or county) (State or foreign country)

10. Usual occupation **—**

11. Industry or business **—**

MOTHER FATHER { 12. Name **FRANK JOSEPH KELLY**
13. Birthplace **HIGGINSVILLE MO.**
(City or town, or county) (State or foreign country)
14. Maiden name **PEGGY WEBSTER**
15. Birthplace **PLEASANT HILL, ILL.**
(City, town, or county) (State or foreign country)

16. (a) Informant **FRANK JOSEPH KELLY**
(b) Address **NEBO, ILL. BOX 171**

17. (a) **PLEASANT HILL, ILL.** (b) Date thereof **10-24-48**
(Burial, ~~—~~) (Month) (Day) (Year)

(c) Place: burial **Pleasant Hill, Ill.**

18. (a) Signature of funeral director **Halcy Mortuary**
(b) Address **Louisiana, Mo.**

19. (a) **10-23-48** (b) **Burnace Ballinger**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Ill.** (b) County **Pike**
(c) City or town **Pleasant Hill**
(If outside city or town limits, write "RURAL")
(d) Street No. **—** (If rural, give location)
(e) Citizen of foreign country? **—** (Yes or No)
If yes, name country **—**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **22, 1948**
year **—** at hour **10:22 A.M.** minute **—** M.

21. I hereby certify that I attended the deceased from **Birth** on **Sept. 2, 1948** to **Oct. 22, 1948**
that I last saw him alive on **Oct 22, 1948** and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Broncho Pneumonia**
Acute Pyelitis & Nephritis (Glomerulonephritis) Duration **1 day**

Due to **—**
Due to **—**

Other conditions **Prematurity**
(Include pregnancy within 3 months of death)

Born 3 mo. prior to expected term

Major findings: Of operations **—**

Of autopsy **—**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **—**
(b) Date of occurrence **—**
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) Means of injury **—**

23. Signature **Robert L. Audrae M.D.**
(M.D. or other)
Address **216 Georgia St. Louisiana, Mo.** Date signed **10/22/48**

RECEIVED

District Health Officer No. 10

District File Number 10-48-184

Date Filed OCT 27 1948

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.
working under my personal supervision.

Signed.....

Licensed Embalmer No.

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Nov

Registration District No. 278

Primary Registration District No. 3054

Registrar's No. 110

1. PLACE OF DEATH:

- (a) County Pike
(b) City or town Louisiana
(c) Name of hospital or institution: _____
(If outside city or town limits, write "RURAL" and name of township)

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____
years, months or days

3. (a) PRINT
FULL NAME

3. (b) If veteran, _____ 3. (c) Social Security
name war _____ No. _____

4. Sex M 5. Color or W 6. (a) Single, widowed, married,
race _____ divorced 5

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____

7. Birth date of deceased Sept 2
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day
hr. _____ min. _____

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

- (b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

- (b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State ILLINOIS (b) County Pike
(c) City or town PLEASANT HILL
(If outside city or town limits, write "RURAL")

- (d) Street No. _____ (If rural, give location)

- (e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____
year 1958 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

- Due to _____

- Due to _____

- Other conditions _____
(Include pregnancy within 3 months of death)

- Major findings:
Of operations _____

- Of autopsy _____

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

22. If death was due to external causes, fill in the following: .

- (a) Accident, suicide, or homicide (specify) _____

- (b) Date of occurrence _____

- (c) Where did injury occur? _____
(City or town) (County) (State)

- (d) Did injury occur in or about home, on farm, in industrial place, in public place?

- While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature _____ (M. D. or other)

- Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

S-33719